

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017717

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3307

STATE FILE NUMBER

FILED APR 23 1963

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis

Length of stay in 1b

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY

OR TOWN

St. Louis

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital; give location)

D.O.A. City Hospital

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS

2227 Rear Franklin Ave

Reside on Farm

Yes ☐ No ☒

## 3. NAME OF DECEASED

(Type or print)

Sarah

Middle

Harris

Last

## 4. DATE OF DEATH

Month

Day

Year

3

9

63

## 5. SEX

Female

## 6. COLOR OR RACE

Negro

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

## 8. DATE OF BIRTH

12/27/13

## 9. AGE (last birthday)

49

## IF UNDER 1 YEAR

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

## 10b. KIND OF BUSINESS OR INDUSTRY

none

## 11. BIRTHPLACE (City and state or country)

Miss.

## 12. CITIZEN OF WHAT COUNTRY

U.S.A

## 13a. FATHER'S NAME

Unknown

## 13b. MOTHER'S MAIDEN NAME

Ada Gentry

## 14. NAME OF HUSBAND OR WIFE

Deceased

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of)

no

no

## 16. SOCIAL SECURITY NO.

[REDACTED]

## 17. INFORMANT

Missouri Tate 2816 Cass Ave.

## 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY)

## IMMEDIATE CAUSE (a)

Massive Intra-thorax Hemorrhage. Rndub:

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

## DUE TO

fractured ribs with laceration of intercostal arteries. suffered in fall in alley in rear of 2027 Franklin, on or about March 8, 1963

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

accident

903.5-44

## PART III. If deceased was female was there a pregnancy in last 90 days.

Yes ☐ No ☐ Unknown ☒

## 19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

## 20a. ACCIDENT

X

## SUICIDE

☐

## HOMICIDE

☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

see above

## 20c. TIME OF INJURY

Hour a.m. p.m.

3-9-63

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

GODDARD 21

## 20f. CITY, TOWN, OR LOCATION

St Louis, Mo

## COUNTY

## STATE

## 21. I attended the deceased from

9:00 A

to and last saw her alive on

## Death occurred at

m on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

## 22b. ADDRESS

1300 Clark

## 22c. DATE SIGNED

3-21-63

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

## 23b. DATE

3/21/63

## 23c. NAME OF CEMETERY OR CREMATORY

Father Dickson

## 23d. LOCATION (City, town, or county)

408 S. Fillmore St. Louis

## 24. FUNERAL DIRECTOR

## ADDRESS

Grant Johnson 2615 Marcus Ave

## 25. DATE RECD. BY LOCAL REG.

MAR 21 1963

## 26. REGISTRAR'S SIGNATURE

Boal Smith M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

This body was not embalmed.

Grant Johnson

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

working under my personal supervision.

Signed CLB - [Signature]

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.